MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

05286 T

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:
County: St. Mary's
City or town: Patuxent River, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Dispensary, U. S. Naval Air Station
Patuxent River, Maryland
How long in hospital or institution? One hour.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Issue
(If outside city or town limits, write RURAL and give nearest town)
Street No. - - - - - - - -
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: BILLINGS, TOM

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Married

8.(b) Name of husband or wife: Mary Billings
8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1882

8. AGE: Years	Months	Days	If less than one day
62	4	13	hrs. min.

9. Birthplace: Washington. Dist. of Columbia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: C.J. Langenfelder & Son Contractors.

FATHER
12. Name: Thomas Billings Sr.
13. Birthplace: Chas Co Md

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Henry Billings
Address: Issue Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-11-45 (month) (day) (year)
Cemetery or crematory: Holy Ghost
Location: Issue Md
18. Funeral director: Heath & Ryon
Address: Waldorf Md
19. May 9 1945 (Date rec'd by registrar) M.L. Moore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 May 1945 at 9:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 1945 to May 8 1945 and that I last saw him alive on 8 May 1945

Immediate cause of death	DURATION
Hemorrhage, cerebral	1 hour
Due to hemorrhage, cerebral	
Due to Arterioclerosis, general	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. H. Gulledge M. D. or other
Address: US NAS Patuxent River Md Date signed: 5-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-2)

CERTIFICATE OF DEATH

05287

Reg. Diat. No. 291

1. PLACE OF DEATH:
County St. Marys
City or town Bridge md. (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County St Marys
City or town Bridge (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John W. Biscoe

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	married

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 69? Months Days If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Waterman

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace " "

MOTHER 14. Maiden name Unknown
15. Birthplace " "

16. Informant John Biscoe
Address St. Inigoes Md.

17. Burial (Burial, cremation, or removal—Which?) Date thereof 5-9-45 (month) (day) (year)
Cemetery or crematory St. Peters
Location Bridge Md.

18. Funeral director E. L. Robinson
Address Dameron Md.

19. May 7 1945 (Date rec'd by Registrar) P. J. Beany M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1945 at 12:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15 1945, to Mch 1 1945
and that I last saw him alive on Mch 1 1945

	DURATION
Immediate cause of death Carcinoma lung (left)	1 Year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm H Pollard M.D. M. D. or other
Address Pearson Rd Date signed 5-6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

05288

Reg. Dist. No. 24

No. G 95 JUN 16 1945

1. PLACE OF DEATH:

County St. Mary's

City or town Leonardtown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 3 mos

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County St. Mary's

City or town Leonardtown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Thomas Butler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	col	

6.(b) Name of husband or wife Mary E. Clark Butler

6.(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) 12-24-1870

8. AGE: Years	Months	Days	If less than one day
74	5	0	hrs. min.

9. Birthplace Benedict, Md. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Benedict Butler

FATHER 13. Birthplace Benedict Md

MOTHER 14. Maiden name Mary Butler

MOTHER 15. Birthplace Benedict Md

16. Informant Elizabeth Hamilton

Address Leonardtown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-26-45 (month) (day) (year)

Cemetery or crematory Leonard Neale

Location Leonardtown Md

18. Funeral director Ross E. Welch

Address Leonardtown Md

19. 5-25-45 (Date rec'd by registrar) 19 45 R. V. Palmer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-24 19 45 at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 5-24 19 45

Immediate cause of death Heart failure — DURATION Hours

Due to Cerebral thrombosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert V. Palmer M. D. or other

Address Leonardtown Md Date signed 5-31-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

T 05289

Reg. Dist. No. 582

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: St Marys

City or town: Holly Wood Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: St Marys

City or town: Holly Wood Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Honey Chapman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years: 75 | Months: — | Days: — | If less than one day: ..... hrs. ..... min.

9. Birthplace: Holly Wood St Marys Md
(Town, county, and state)

10. Usual occupation: Labor

11. Industry or business

FATHER — 12. Name: Sam Chapman

13. Birthplace: St Marys Co

MOTHER — 14. Maiden name: Permilla Smallwood

15. Birthplace: St Marys Co

16. Informant: Catharine Frederick

Address: Holly Wood Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 13 1945 (month) (day) (year)

Cemetery or crematory: St Johns

Location: Holly Wood Md

19. Funeral director: W. O. Mattingly Son

Address: Leonardtown Md

19. 5/13 45 (Date rec'd by registrar) Edwards Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11th 1945, at 2.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1943 to May 11th 1945

and that I last saw h... alive on ... May 9th 1945

Immediate cause of death	DURATION
Anemia	
Due to: Nephritis Chronic	3 yrs
Due to: Arterial Sclerosis	6-7
Other conditions: Prostatitis Chronic	5-6

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of

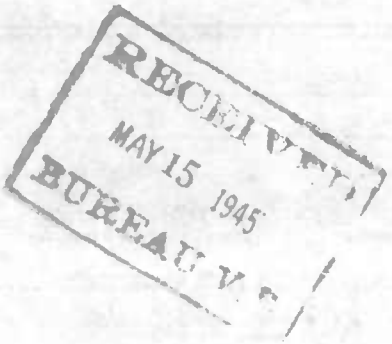
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury ..... Injured at work?

23. SIGNATURE: H F Greenwell Jr M.D. or other

Address: Leonardtown Md Date signed: May 14 1945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19

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 190

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:
County: St Marys
City or town: near Park Hall (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all his life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: St Mary
City or town: Park Hall (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George Brent Fenwick
3. (b) Social Security Number

4. Sex: Male
5. Color or race: Col
6.(a) Single, married, widowed, or divorced: S
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Jan 1942

8. AGE:

Years	Months	Days	If less than one day
3	2	—	... hrs. ... min.

9. Birthplace: St Marys Co Md (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name: Ambrose Fenwick
13. Birthplace: St Marys Co Md
MOTHER 14. Maiden name: Bertha Fenwick
15. Birthplace: St Marys Co Md
16. Informant: Bertha Fenwick
Address: Park Hall
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 14 1946 (month) (day) (year)
Cemetery or crematory: Holy Face Cemetary
Location: near Great Mills Md
18. Funeral director: Wm C Mattingly [illegible]
Address: Leonardtown Md
19. Oct 14 1946 (Date rec'd by registrar) Cumulin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7th 1945, at — M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Saw thy discovered the remains Oct 13 1946
and that I last saw h... alive on ... 19...

Immediate cause of death: Exposure & Exhaustion — DURATION

Due to: Having wandered from home & and not being found

Due to: the only remains were the skull and a few pieces of long

Other conditions: bones with few teeth and some small pieces of clothing & one shoe

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accidental Date of: May 7-1945
Where did injury occur? Cause natural (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J F Greenwell Dy Coroner M. D. or other
Address: Leonardtown Md Date signed Oct 13-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

05290

Reg. Dist. No. 2-6

1. PLACE OF DEATH:
County: St Mary's
City or town: Rural District
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: St. Mary's
City or town: Rural Clements
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Bernard William Freeman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

B.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 3-27-1876

8. AGE: Years: 64 | Months: 1 | Days: 28 | If less than one day: hrs. ..... min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business: Fisherman

FATHER
12. Name: William Milstead
13. Birthplace: Baltimore Md

MOTHER
14. Maiden name: Cecil Josephine Williams
15. Birthplace: St Marys Co

16. Informant: Mrs Francis Hubert
Address: Clements

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-29-43 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: Bushwood

18. Funeral director: W. C. Madigan
Address: Leonardtown Md

19. 3-30-1943 (Date rec'd by registrar) R. V. Palmer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29 1943 at 8:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27 1943, to March 29 1943
and that I last saw h... alive on March 29 1943

Immediate cause of death: Cerebral apoplexy — DURATION: Sudden

Due to: — DURATION:

Due to: — DURATION: 2 hrs.

Other conditions: — DURATION:

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Robert V. Palmer M. D. or other
Address: Avenue Md Date signed: 3-20-43

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

1

05291

Reg. Diat. No. 291

1. PLACE OF DEATH:

County St. Marys

City or town Rural Hermanville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys

City or town Rural, Hermanville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah Gordon

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1872

8. AGE: Years	Months	Days	If less than one day
72	9	1	..... hrs. ..... min.

9. Birthplace Hermanville Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER

12. Name James Gordon

13. Birthplace Hermanville Md.

MOTHER

14. Maiden name Josephine Holly

15. Birthplace Hermanville Md

16. Informant Frank Gordon

Address Hermanville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13, 45 (month) (day) (year)

Cemetery or crematory Holy Face

Location Great Mills Md.

18. Funeral director Wm. C. Mattingly Sons

Address Leonardtown Md

19. May 13 1945 (Date rcvd by registrar) P. J. Bean M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1945 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1942, to May 13 1945

and that I last saw him alive on May 10 1945

Immediate cause of death	DURATION
Arteriosclerotic heart disease	5 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. J. Bean M.D.
M. D. or other

Address Great Mills Md Date signed 5/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

05292 Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: St. Mary's
City or town: Leonardtown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: St. Mary's Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: St. Mary's
City or town: Ridge Md. (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Stephan P. Green

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Edie G. Green
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Aug. 26, 1868

8. AGE: Years: 76 ~~67~~ | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: William Green
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annie Lumpkins
15. Birthplace: Maryland

16. Informant: Bernard F. Green
Address: Ridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/5/45 (month) (day) (year)
Cemetery or crematory: St. Michaels
Location: Ridge, Md.

18. Funeral director: E. T. Robinson
Address: Hamesson, Md.

19. May 3 1945 (Date rec'd by registrar) P. J. Beam, M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 1945 at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1934 to May 2 1945 and that I last saw him alive on April 30 1945

Immediate cause of death	DURATION
Chronic myocarditis	2 years
Due to: Interstitial nephritis	10 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: P. J. Beam, M.D. M. D. or other
Address: Great Mills, Md. Date signed: 5-3-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-0)

CERTIFICATE OF DEATH

T 05293

Reg. Dist. No. 582

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: St. Mary's

City or town: Leonardstown, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days Life

Hospital, institution, or street address where death occurred: St. Mary's Hospital

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: St. Mary's

City or town: Clements
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Clarence M. Guy, Sr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Margaret Rose Guy

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Aug. 8th, 1877

8. AGE: Years	Months	Days	If less than one day
67	9	8	...hrs. ...min.

9. Birthplace: Clements, St. Mary's Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business:

FATHER
12. Name: John C. Guy
13. Birthplace: Md.

MOTHER
14. Maiden name: Alice Mattingly
15. Birthplace: Md.

16. Informant: Mattingly Guy
Address: Clements, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-19-45 (month) (day) (year)

Cemetery or crematory: St. Josephs

Location: Morganza, Md.

19. Funeral director: W. C. Mattingley Sons

Address: Leonardstown, Md.

19. 5/17 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16th 19 45, at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1940 19... to May 16 1945 and that I last saw h... alive on May 16 1945.

Immediate cause of death	DURATION
Chronic Hysterectomy	
Due to	
Due to	
Other conditions Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank A. Cavaleer M. D. or other

Address: Leonardtown Date signed: 5/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

CERTIFICATE OF DEATH

05294 T

Reg. Dist. No. 282

1. PLACE OF DEATH:
County: St Marys
City or town: Leonardstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: St Marys Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: St Marys
City or town: California
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Lawrence Kalby Holly

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	married

6.(b) Name of husband or wife: Sarah Kalby
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Aug. 14, 1882

8. AGE: Years: 63 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Waiter

11. Industry or business:

FATHER
12. Name: James Kalby
13. Birthplace: Maryland

MOTHER
14. Maiden name: Estella Frazier
15. Birthplace: Maryland

16. Informant: Sarah Kalby
Address: California, Md.

17. Burial (Burial, cremation, or removal — which?) Date thereof: 5-11-45 (month) (day) (year)
Cemetery or crematory: St Luke
Location: Ridge Md.

18. Funeral director: C B. Robinson
Address: Leonardtown Md.

19. 5/11/45 (Date rec'd by registrar) Aurelia Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/9/45, at 11 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/9/45 to 5/9/45 and that I last saw him alive on 5/9/45

Immediate cause of death	DURATION
Post operative shock	1 hour
Due to Operation for	
Due to Acute appendicitis	6 days
Other conditions Diffuse peritonitis	4 days

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: E.X. Thompson M.D.
M. D. or other
Address: Drayden — Date signed: 5/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45)

05295 T

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:
County St. Mary's
City or town St. Inigoes (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County St. Mary's
City or town St. Inigoes Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James T. Jenifer

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	widower

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Sept 23 1866

8. AGE: Years 78 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Labor

11. Industry or business

FATHER 12. Name James Jenifer
FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Elizabeth White
MOTHER 15. Birthplace Maryland

16. Informant Viola Foster
Address St. Inigoes

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-10-45 (month) (day) (year)
Cemetery or crematory St. Peters
Location Ridge Md.

18. Funeral director E. L. Robinson
Address Dameron, Md

19. May 10, 1945 (Date received by registrar) P. J. Bean M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1945 at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1943 to May 1945
and that I last saw him alive on May 7 1945

	DURATION
Immediate cause of death: Carcinoma of the tongue	3 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE P. J. Bean M. D. or other
Address Great Mills Md Date signed 5-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

05296

Reg. Diat. No. 782

1. PLACE OF DEATH:

County: St. Marys County

City or town: Calloway, Maryland (Rural)
(If nutside city nr town limits, write RURAL and give nearest town)

How long in above place of death? Passenger in automobile

Hospital, Institution, or street address where death occurred:
USNAS Dispensary, Patuxent River, Md.

How long in hospital or institution? Dead upon arrival.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mntber)

State: New York County:

City or town: St. Johnsonville, N.Y.
(If nntside city nr town limita, write RURAL and give nearest towu)

Street No. RD #2
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JOHNSON, Harold Wagner 443950

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 27, 1922

8. AGE: Years	Months	Days	If less than one day
23	3	21	hrs. min.

9. Birthplace: St. Johnsonville, New York
(Town, county, and state)

10. Usual occupation: Corporal

11. Industry or business: U. S. Marine Corps

FATHER 12. Name: Jesse Johnson

13. Birthplace: Unknown

MOTHER 14. Maiden name: "

15. Birthplace: "

18. Informant: U. S. Navy.

Address: Patuxent River, Md.

17. (Burial, cremation, or removal. Which?) Transportation Date thereof 5-19-45 (month) (day) (year)

Cemetery or crematory: St. Johnsonville

Location: N.Y.S. New York.

18. Funeral director: Robinson's Funeral Home

Address: Leonardtown, Maryland

19. 5/19/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 19 45, at 2:10 AM

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from

dead 19, to 19

and that I last saw him alive on 5-18 19 45

Immediate cause of death: Intracranial Injury	DURATION
Due to: Compound comminuted fracture, right frontal and temporal bone.	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Antopsy results:

PHYSICIAN: Please underline the cause to which death shonld be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 5-18-45

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Automobile accident Injured at work? No

23. SIGNATURE: R. H. Driscoll

R. H. DRISCOLL, Lt. (MC) USN
M. D. or other

Address: Patuxent River, Md. Date Signed: 5-18-45

Former Executive Officer

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94

05297

CERTIFICATE OF DEATH

Reg. Dist. No. 286

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County St. Mary's

City or town Ridge Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County St Mary's

City or town Rural Hum
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, gives LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James Albert Latham

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6.(b) Name of husband or wife Alice Maud Latham

6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept. 6 - 1880

8. AGE:

Years	Months	Days	If less than one day
65	1	0	...hrs. ...min.

9. Birthplace Morganza St Mary's Md
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business

FATHER 12. Name Joseph Latham

13. Birthplace Morganza

MOTHER 14. Maiden name Mary Guy

15. Birthplace Morganza

16. Informant Mary Guy Latham

Address Hardy Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 - 7 - 45 (month) (day) (year)

Cemetery or crematory Sacred Heart

Location Brkhead Md

18. Funeral director Mattingly Bros.

Address Leonardtown Md

19. 5 - 7 19 45 R. V. Palmer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 - 7 - 19 45; at 1 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4-20- 19 45; to 4-26- 19 45

and that I last saw h... alive on 4-26- 19 45

Immediate cause of death	DURATION
Acute Indigestion	Sudden
Due to	
Due to	
Other conditions Coronary thrombosis, acute bundle branch block	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert V. Palmer
M. D. or other

Address Avenue Md Date signed 5-7-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

T 05298

Reg. Dist. No. 282

1. PLACE OF DEATH:
County: St Marys
City or town: Abell Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: St. Mary's
City or town: Leonardtown Abell
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Maddox

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Color	Single

9.(b) Name of husband or wife
9.(c) If alive, give age 47 years
7. Birth date of deceased (mo., day, yr.): 1897

8. AGE: Years	Months	Days	If less than one day
47			hrs. min.

9. Birthplace: Oakley St. Mary's Co. Md. (Town, county, and state)
10. Usual occupation: Handy man
11. Industry or business
FATHER 12. Name: Maddox
FATHER 13. Birthplace: Md.
MOTHER 14. Maiden name: Maria Maddox
MOTHER 15. Birthplace: Md.
18. Informant: James Lee Maddox
Address: Indian Head. P.O Box 512 Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof June 2nd 1945 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: Bushwood, Md.
18. Funeral director: W. C. Mattingley Sons
Address: Leonardtown, Md.
19. 6/1 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30th 1945 at 5:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30th 1945 after death 19 and that I last saw h alive on 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A. F. Greenwell Coroner M. D. or other
Address: Leonardtown Md. Date signed April 9th 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

05299 T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (460)

CERTIFICATE OF DEATH

Reg. Diat. No. 282

1. PLACE OF DEATH:
County St Marys
City or town Abells Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 53 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Insfitution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County St Marys
City or town Abells Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Agnes Madeline Brid Mattingly

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife W H Mattingly
6.(c) If alive, give age 54 years
7. Birth date of deceased (mo., day, yr.) May 28 1891

8. AGE: Years	Months	Days	If less than one day
53	11	9	....hrs. ....min.

9. Birthplace Piney Grove St Marys Co Md (Town, county, and state)
10. Usual occupation House Wife
11. Industry or business

FATHER
12. Name James H. Bailey
13. Birthplace St Marys Co

MOTHER
14. Maiden name Julia Russell
15. Birthplace St Marys Co

16. Informant W H Mattingly
Address Abells Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10 1945 (month) (day) (year)
Cemetery or crematory Sacred Heart cemetery
Location Bush Wood Md

18. Funeral director W C Mattingly Sons
Address Leonardtown Md

19. 5 9 45 (Date recd by registrar) Caveaen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1945, at 9.45 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1944, to May 7 1945
and that I last saw h.. alive on May 6 1945

Immediate cause of death	DURATION
Carcinoma Rectum	March 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma rectum - Glands in mesentery Date of op. April 1944
Autopsy results Some done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Aloysius C. Welch M D M. D. or other
Address Chaptico Md Date signed 5/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

(T)

VS A15

053010

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

Reg. Dist. No. 297

1. PLACE OF DEATH:

County: St Marys

City or town: St Georges Island Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: St Marys

City or town: St Georges Island Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Myrtle Leora Poe

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Alfred L. Poe

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): July 20 - 1905

8. AGE: Years	Months	Days	If less than one day
39	9	27	...hrs. ...min.

9. Birthplace: Charles Co Md (town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER 12. Name: Albert Bateman

FATHER 13. Birthplace: Charles Co Md

MOTHER 14. Maiden name: Mary Thorpe

MOTHER 15. Birthplace: King George Co Va

18. Informant: Alfred L. Poe

Address: St Georges Island Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18 1945 (month) (day) (year)

Cemetery or crematory: St Francis Cemetery

Location: St Georges Island Md

18. Funeral director: W. C. Watts Funeral Home

Address: Leonardtown Md

19. 5/17/45 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1945, at 3.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1944 to May 16 1945 and that I last saw h[er] alive on May 15 1945

Immediate cause of death	DURATION
Carcinoma of Lung and small intestine	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Intestines

Date of op. 3/13/45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. X. Thompson M. D. or other

Address: Brayden, Md Date signed 5/16/45

0530 11

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-d

CERTIFICATE OF DEATH

Reg. Dist. No. 287

1. PLACE OF DEATH:

County St Marys

City or town Leonardtown Md R. F. D. # 1
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County St Marys

City or town Leonardtown Rural # 1
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Marie Ann Beidler Bramble Tabin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

B.(b) Name of husband or wife William E. Tabin

8.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Dec 27 1897

8. AGE:

Years	Months	Days	If less than one day
47	4	13	hrs. min.

9. Birthplace Lanham Prince George Md
(Town, County, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER 12. Name Samuel Beidler

13. Birthplace Wood Stock Va

MOTHER 14. Maiden name Lucie Lockwood

15. Birthplace Va

16. Informant William E. Tabin

Address Leonardtown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-12-45 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Suitland, Md.

18. Funeral director W. C. Matthews & Son

Address Leonardtown Md

19. 6/12 19 45 Cavaliers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 19 45, at 1.45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 19 44, to May 10 19 45

and that I last saw h[illegible] alive on May 8 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 minute
Due to Chronic Hypertension	Several years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert T. Fuche M.D.
M. D. or other

Address Leonardtown, Md. Date signed 5/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


MAY 15 1945